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Insurer Cost and Utilization Measures
Report Deadline: March 31, 2015

March 16, 2015 GUIDANCE CLARIFICATIONS

If you are unable to make any of the following distinctions in your utilization measure report, please submit the report as originally requested. If necessary, please provide an explanation of how the calculation varied from specifications.

Hospital Admissions

- Payors should include all acute facilities.
    - Exclude non-acute facilities such as swing bed designations, long-term care hospitals, and rehabilitation hospitals.
- Hospitalizations that occur outside of Montana should also be included in the report.
- Multiple components of care during a continuous episode should be rolled into a single admission count, as long as they are all inpatient care.

Emergency Room Visits

- Report Observation Stays as a separate category and exclude them from ER visits and hospitalizations.
- Report ER visits that lead to a hospitalization in a separate category from ER visits that do not lead to a hospitalization.
- Report multiple ER visits on the same day as separate events.

Introduction

Montana insurers with PCMH contracts are required by Patient-Centered Medical Home Act (Act), to report on compliance with the uniform set of cost and utilization measures. According to New Rule II, Mar. Notice No. 6-212, the first report from PCMH payors on utilization review measures is due to the Montana Office of the Commissioner of Securities and Insurance (CSI) on March 31, 2015. Submit reports to Amanda Roccabruna Eby at aeby@mt.gov.

Payors must submit data from calendar year 2014 on two utilization measures: ER visits and hospitalizations. The prescribed method for measuring and reporting is described below. Flexibility is allowed for attribution methods, if approved by the Commissioner. However, a suggested attribution method is described below. Payors that do not have an attributed PCMH population in 2014 will report these metrics for their entire population.

Method for measuring and reporting the required utilization metrics:

1. **Method for measuring and reporting of Emergency Room Visits (ER Visits per 1,000*)**

ER Visits per 1,000 is the average number of emergency room facility visits provided under medical coverage, per 1,000 members per year. The number of visits is based on the count of unique patient and service date combinations (ER Visits/ (Member Months/1000))*12.

Additionally:
If attributed population data is available, this calculated rate will be applied for comparison to the population consisting of the payor's entire fully insured book of business, and to the population consisting of members with 7 or more months of contiguous attribution to a PCMH within a single calendar year for the reporting period.

2. **Method for measuring and reporting of Hospitalization Rates (Admits per 1,000*)**

Admits per 1,000 is the average number of acute admissions per 1,000 members with medical coverage per year (Admits/ (Members Months/1000))*12.

Additionally:
If attributed population data is available, this calculated rate will be applied for comparison to the population consisting of the payor's entire fully insured book of business, and to the population consisting of members with 7 or more months of contiguous attribution to a PCMH within a single calendar year for the reporting period.

Suggested Attribution Method:

1) PCMH is established when an approved entity notifies payor of their intent to participate and signs an agreed upon contract.
2) PCMH sends payor a list of participating healthcare providers **practicing** Primary Care within the following specialty categories:
    a. Family Practice
    b. Internal Medicine
    c. Internal Medicine w/ subspecialty of Endocrinology (for diabetic patients)
    d. Pediatrics
    e. OB/GYNs
    f. General Practice
    g. Nurse Practitioners and Physician Assistants practicing in one of the above specialties
3) Member eligibility is established based on active payor membership for the specified time period & exclusion of certain lines of business.
4) Member qualification for participation in PCMH:
    a. Member- Provider relationship established using 2-year retrospective payor claims utilization (provider type, volume, and frequency of visits).
5) PCMH and payor repeat the above process on a monthly basis to set agreed upon provider and patient panel for reporting and compensation purposes.

Please Note: This is one proposed attribution method. Payors may develop other attribution methods, ***as approved by the commissioner.***